

# **Green Mountain Care Board Accountable Care Organization Oversight**

## **FY 2020 Preliminary Recommendations**

December 11, 2019

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# Today's Agenda

1. Background on ACO Oversight
  - Public Comment Summary
2. Certification Eligibility Verification
3. Budget Review
  - Payer programs
  - Provider network
  - Scale
  - Model of care & population health
  - Quality
  - Administrative Expenses
  - Risk/reserves
  - Evaluation
4. 2020 Summary of Recommendations
5. Next Steps
6. Questions/Public Comment

# Acronym List

- ACO—Accountable Care Organization
- APM—All-Payer Model
- ASO—Administrative Services Only
- BCBS—Blue Cross Blue Shield
- CMMI—Centers for Medicare & Medicaid Innovation
- CMS—Centers for Medicare & Medicaid Services
- FFS—Fee-for-service
- FPP—Fixed Prospective Payment
- FQHC—Federally Qualified Health Center
- GMCB—Green Mountain Care Board
- HCA—Health Care Advocate
- HSA—Health Service Area
- OCV—OneCare Vermont
- QHP—Qualified Health Plan
- PCMH—Patient-Centered Medical Home
- PCP—Primary Care Provider
- PHM—Population Health Management
- PMPM—Per Member Per Month
- PY—Performance Year
- SNF—Skilled Nursing Facility

# Background

# The Vermont All-Payer ACO Model: Tackling Unsustainable Cost, Improving Quality and Outcomes

**PROBLEM:** The cost of health care in Vermont is increasing at an unsustainable rate and there is room to improve the health of Vermonters and the quality of care they receive.

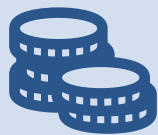
## **STRATEGY:**

- *Care Delivery:*
  - Integrated and coordinated delivery care across the continuum
  - Primary care and prevention
  - Delivery of care in lower cost settings
  - Reduce duplication of services
- *Payment:*
  - Replace fee-for-service reimbursement with population-based payments
  - Instead of rewarding volume, providers accept responsibility for the health of a group of patients in exchange for a fixed amount of money

## **INTERVENTION:**

- Statewide ACO model
- Majority of Vermont providers participate in aligned programs across Medicare, Medicaid, and commercial payers;
  - Agreement signed in 2016, enabling Medicare's participation.

# The Vermont All-Payer Accountable Care Organization Model



## Test Payment Changes

Population-Based Payments  
Tied to Quality and  
Outcomes

Increased Investment in  
Primary Care and  
Prevention



## Transform Health Care Delivery

Invest in Care Coordination

Incorporation of Social  
Determinants of Health

Improve Quality



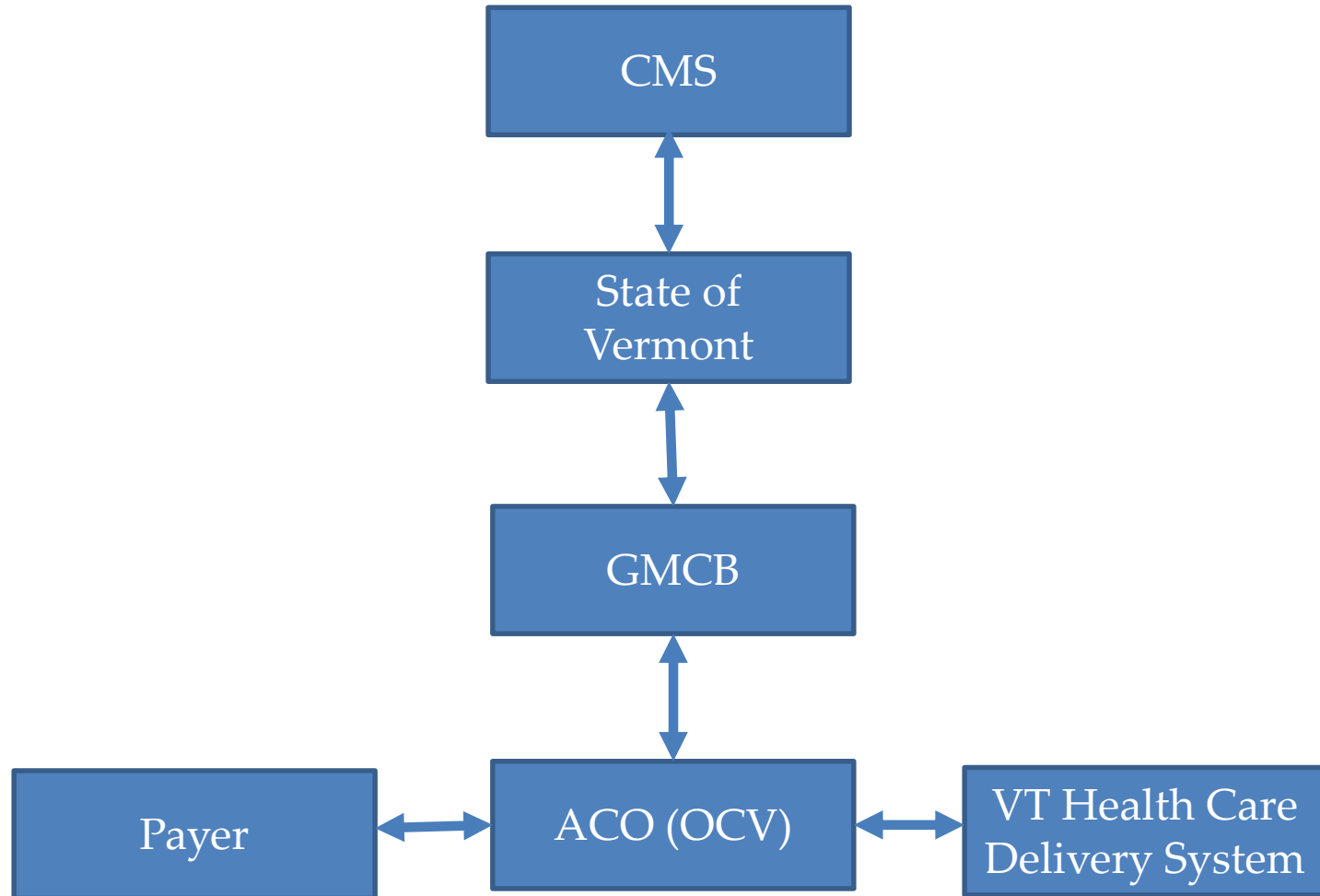
## Improve Outcomes

Improved access to primary  
care

Fewer deaths due to suicide  
and drug overdose

Reduced prevalence and  
morbidity of chronic disease

# APM: Delivery System Reform Partners



# Vermont APM Partners

## Center for Medicare and Medicaid Innovation (CMMI)

- **Model design, operations, and monitoring** to support Agreement implementation
- **Implement Vermont Medicare ACO Initiative** (payer), a Vermont-tailored Medicare ACO model

## Green Mountain Care Board (GMCB)

- **Health system regulation** to support Model goals (ACO oversight, Medicare ACO program design and rate setting, hospital budgets, and more)
- **Monitoring and reporting to CMMI** on cost, scale and alignment, quality, and more

## Governor, Vermont Agency of Human Services (AHS) *Including Medicaid*

- **Vermont Medicaid Next Generation ACO Program** (payer)
- **Reporting to CMMI**, including plans for integrating public health and mental health, substance use disorder, and long-term care spending into financial targets

## ACO (OneCare Vermont) and Vermont Providers

- **Contract with payers** to accept non-FFS payments and increase Model scale
- **Work with provider network** to implement delivery system changes intended to control cost growth and improve quality and access

## Private Insurers and Vermont Businesses

- **Contract with ACO** to pay non-FFS payments on behalf of covered lives in alignment with the Model
- **Work with self-insured employers** as a TPA/ASO to demonstrate Model progress and bring new self-insured lives under the Model

*All-Payer Model Agreement Signatories*



# All-Payer ACO Model Agreement

## What is Vermont (State) responsible for?

### Scale and Cost Growth

- Limit cost growth
  - All-Payer Growth Target: Compounded annualized growth rate < 3.5%
  - Medicare Growth Target: 0.1-0.2% below national projections
- Ensure alignment across payers, which supports participation from providers and increases “scale”
  - All-Payer Scale Target – Year 5: 70% of Vermonters
  - Medicare Scale Target – Year 5: 90% of Vermont Medicare Beneficiaries

### Population Health and Quality Measures

- Performance on **20 quality measures**, including three population health goals for Vermont
  - Improve access to primary care
  - Reduce deaths due to suicide and drug overdose
  - Reduce prevalence and morbidity of chronic disease

*\*ACO responsible for meeting quality measures embedded within payer contracts*

# GMCB APM Regulatory Responsibilities

**Goal #1:** Vermont will reduce the rate of growth in health care expenditures

**Goal #2:** Vermont will ensure and improve quality of and access to care

## *GMCB Regulatory Levers*

ACO Budget Review

ACO Certification

Medicare ACO Program Design and Rate Setting

Hospital Budget Review

Health Insurance Rate Review

Certificate of Need

# ACO Oversight

Oversight of Accountable Care Organizations  
([18 V.S.A. § 9382](#) and [Rule 5.000](#))

1. **Certification:** occurs one-time following application for certification then eligibility verifications done annually
2. **Budget:** review of ACO budget occurs annually

# Quantifying GMCB's 2020 ACO Oversight

For the 2020 Fiscal Year, GMCB Staff reviewed *approximately*...

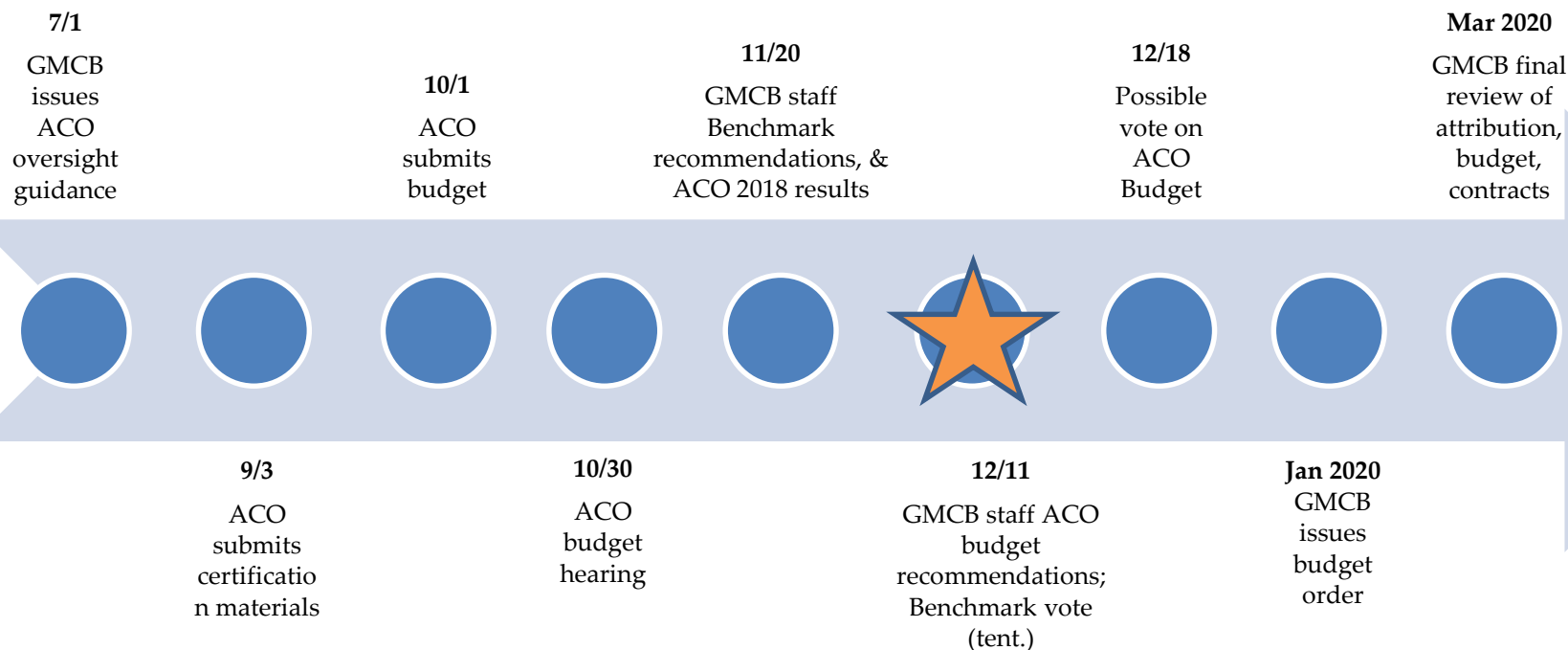
1. Budget: **714 pages**
2. Certification: **46 pages** + relevant policies and procedures
3. Public Comment: **26 pages** (as of 12/3)

Further, together the GMCB and the HCA asked OCV **88 questions** across the Oversight Process in 2020, not including sub-questions.

# ACO Oversight & APM Goals

APM Goal	ACO Oversight (Annual Budget Review)
Limit Cost Growth	How are the ACO's investments and programs limiting health care cost growth in the near and long term?
Achieve Scale	How do the ACO's payer programs and provider network impact scale?
Improve Quality (20 Quality Measures)	How are the ACO's investments and programs expected to improve quality?
Improve Population Health <ol style="list-style-type: none"><li>1. Improve access to primary care</li><li>2. Reduce deaths due to suicide and drug overdose</li><li>3. Reduce prevalence and morbidity of chronic disease</li></ol>	How will the ACO's investments improve the three population health outcomes outlined in the APM?

# ACO Oversight Timeline FY2020



*Note: Special public comment period has been open October 1st through when the Board votes on the budget submission.*

# Public Comment Summary

**GMCB received 16 public comments between October 1<sup>st</sup> and December 11<sup>th</sup>\* from:**

- Vermont Association of Hospitals and Health Systems
- Office of the Health Care Advocate
- Ethan Parke
- Gena Melissa (2)
- Julie Wasserman
- Vermont Health Care Association
- Southwestern Vermont Health Care
- Gifford Medical Center
- Vermont Care Partners
- Bi-State Primary Care Association
- Northeast Kingdom Human Services
- Northern Counties Health Care
- Support and Services at Home
- Vermont Foodbank
- UVMHN Home Health & Hospice

## **Major themes included:**

- Primary care and social service providers benefit from care coordination support from OneCare
- Primary care and social service providers noted that OneCare supports population health investments to the benefit of local communities
- An FQHC and private citizens noted that scale is not yet achieved, which must be considered when thinking about results
- Consensus of commenters is that GMCB should review OneCare's budget critically and closely
- Private citizens commented that GMCB should evaluate and address OneCare's deficiencies

*\*GMCB is accepting public comments until a vote is held on OneCare's budget*

# FY20 ACO Certification Eligibility Verification



# FY20 Certification Eligibility Verification: Process

## 5.305 Annual Eligibility Verifications

- a) An ACO must annually submit to the Board an eligibility verification which:
- I. verifies that the ACO continues to meet the requirements of the 18 V.S.A. § 9382 and this Rule; and
  - II. describes in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in sections 5.201 through 5.210 of this Rule that the ACO has not already reported to the Board.

### Timeline 2019:

- Posted form **July 1**
- Submission received **September 3**
- Responses to follow-up questions received **Oct 16 & Nov 22/Dec 2**
- Staff presentation of monitoring and reporting conclusions **December 11**

# ACO Oversight: Certification Criteria

The GMCB must ensure that the ACO meets criteria in the following ten sections from Rule 5.000:

- 5.201 - Legal Entity
- 5.202 - Governing Body
- 5.203 - Leadership and Management
- 5.204 - Solvency and Financial Stability
- 5.205 - Provider Network
- 5.206 - Population Health Management and Care Coordination
- 5.207 - Performance Evaluation and Improvement
- 5.208 - Patient Protections and Support
- 5.209 - Provider Payment
- 5.210 - Health Information Technology

# FY20 Certification Eligibility Verification

Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY20 Staff Conclusions & Additional Monitoring
Legal Governing Body, Leadership, & Management 5.201-5.203	<ul style="list-style-type: none"> <li>• ACO as a separate legal entity</li> <li>• Authorization to do business in VT</li> <li>• Governance, organizational leadership &amp; management structure</li> <li>• Transparency of governing processes</li> <li>• Mechanism for consumer input</li> </ul>	<ul style="list-style-type: none"> <li>• Operating Agreement</li> <li>• Compliance Plan</li> <li>• Conflict of Interest policy</li> <li>• Governance, leadership, and organizational charts</li> </ul>	<ul style="list-style-type: none"> <li>• Policies up for review Q4</li> <li>• Resumes for Executive team</li> </ul>
Solvency & Financial Risk 5.204	<ul style="list-style-type: none"> <li>• Mechanisms/processes for assessing legal and financial risks</li> <li>• Financial stability/solvency</li> </ul>	<ul style="list-style-type: none"> <li>• Quarterly financial statements</li> <li>• Finance Committee Charter</li> </ul>	<ul style="list-style-type: none"> <li>• Require more robust documentation of risk analysis and assessment submitted to the GMCB</li> </ul>

# FY20 Certification Eligibility Verification

Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY20 Staff Conclusions & Additional Monitoring
Provider Network 5.205	<ul style="list-style-type: none"> <li>Written agreements with ACO Participants</li> <li>Criteria for accepting providers</li> <li>Provider appeals</li> </ul>	<ul style="list-style-type: none"> <li>Provider agreements</li> <li>Network Development Strategy</li> <li>Network Support and Access Policy; Provider Appeals Policy</li> </ul>	<ul style="list-style-type: none"> <li>2021 Network Development Strategy recommendation (<i>See Budget recommendation</i>)</li> </ul>
Population Health Management & Care Coordination 5.206	<ul style="list-style-type: none"> <li>Coordination of services among Payers, Participants, and non-Participant providers, incl. community-based providers</li> <li>Care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Care Coordination &amp; Disease Management Policy</li> <li>Care Coordination and Training &amp; Responsibilities</li> <li>Utilization Management Plan</li> </ul>	<ul style="list-style-type: none"> <li>Policies up for review Q4</li> <li>Require more robust monitoring and evaluation plan for community-specific population health investments, i.e. innovation fund and specialty pilots (<i>See Budget recommendation</i>)</li> </ul>

# FY20 Certification Eligibility Verification

Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY20 Staff Conclusions & Additional Monitoring
Performance Evaluation & Improvement 5.207	<ul style="list-style-type: none"> <li>A Quality Improvement Program actively supervised by the ACO's clinical director or designee that identifies, evaluates, and resolves potential problems and areas for improvement.</li> </ul>	<ul style="list-style-type: none"> <li>Quality Improvement Procedure and Utilization Management Plan</li> <li>Clinical Priorities and Quality Improvement Plan</li> </ul>	<ul style="list-style-type: none"> <li>Policies/procedures up for review Q4 and Q1</li> </ul>
Patient Protections & Support 5.208	<ul style="list-style-type: none"> <li>Enrollee freedom to select their own health care providers</li> <li>ACO may not increase cost sharing or reduce services under enrollee health plan</li> <li>Patients are not billed on the event an ACO does not pay a provider</li> <li>ACO maintains grievance and complaint process</li> </ul>	<ul style="list-style-type: none"> <li>Patient Complaint and Grievance Policy</li> <li>Bi-annual complaint and grievance reporting to GMCB and HCA</li> <li>Beneficiary notification letters</li> </ul>	<ul style="list-style-type: none"> <li>Review policies Q4</li> <li>Semi-annual complaint and grievance information. Continue to review public comment submitted to the Board and collect feedback through the GMCB's Advisory Committees</li> </ul>

# FY20 Certification Eligibility Verification

Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY20 Staff Conclusions & Additional Monitoring
Provider Payment 5.209	<ul style="list-style-type: none"> <li>• Administer provider payments</li> <li>• Alternative payment methodologies coupled with mechanisms to improve or maintain quality/access</li> <li>• Alignment of ACO-payer incentives and ACO-provider incentives</li> <li>• Provider appeals</li> </ul>	<ul style="list-style-type: none"> <li>• FPP Distribution Procedure</li> <li>• PCCM and PHPM Distribution Procedure</li> <li>• VMNG Advanced Community Care Coordination Payments</li> <li>• QI Procedure</li> <li>• VBIF Distribution Policy</li> <li>• Settlement Policy and Reporting</li> <li>• Provider Appeals Policy</li> </ul>	<ul style="list-style-type: none"> <li>• Policies up for review Q4</li> </ul>
Health Information Technology 5.210	<ul style="list-style-type: none"> <li>• Data collection and integration</li> <li>• Data analytics</li> <li>• Integration of clinical and financial data system to manage risk</li> </ul>	<ul style="list-style-type: none"> <li>• Care Coordination &amp; Disease Management Policy</li> <li>• Care Coordination Training &amp; Responsibilities Policy</li> <li>• Utilization Management Plan</li> <li>• Data Use Policy</li> <li>• Privacy &amp; Security Policy</li> </ul>	<ul style="list-style-type: none"> <li>• Policies up for review Q4</li> </ul>

# FY20 Certification Eligibility Verification

Rule 5.000 & Statute	Key Criteria	Ongoing Monitoring & Reporting	FY20 Staff Conclusions & Additional Monitoring
Mental Health Access § 9382(a)(2)	<ul style="list-style-type: none"> <li>• ACO role vs. payer role</li> <li>• Financial incentives</li> <li>• Care coordination</li> <li>• Programs or initiatives</li> <li>• Use of data, quality measurement, and clinical priorities</li> </ul>	<ul style="list-style-type: none"> <li>• Performance on mental health related quality measures in payer contracts</li> <li>• Quality Improvement Plan</li> <li>• Clinical Priorities</li> <li>• Report on collaboration with Das on 42 CFR Pt. 2</li> </ul>	<ul style="list-style-type: none"> <li>• Continue monitoring</li> </ul>
Payment Parity § 9382(a)(3)	<ul style="list-style-type: none"> <li>• ACO role vs. payer role</li> <li>• Steps to minimize payment differentials</li> </ul>	<ul style="list-style-type: none"> <li>• Interim and annual monitoring of comprehensive payment reform program</li> </ul>	<ul style="list-style-type: none"> <li>• Continue monitoring</li> </ul>
Addressing Childhood Adversity § 9382(a)(17) § 5.403(a)(20)	<ul style="list-style-type: none"> <li>• Connections among ACO providers</li> <li>• Collaboration on quality outcome measures</li> <li>• Incentives for community providers</li> </ul>	<ul style="list-style-type: none"> <li>• Plan and timeline</li> <li>• Social determinants risk scores</li> <li>• Screening tools</li> <li>• Program expansion</li> <li>• Analytics</li> </ul>	<ul style="list-style-type: none"> <li>• Continue monitoring</li> </ul>

## FY20 Certification Eligibility Verification: Monitoring and Reporting

OCV to submit...	When?
Updated and relevant plans, policies, procedures, agreements/contracts, subcommittee charters, and governing documents	Quarterly, semi-annually, or annually as determined necessary by staff in collaboration with OneCare
Financial statements	Quarterly
Executive team resumes	Upon hire
Financial and legal vulnerability assessment	Annually
Network Development Strategy	Annually
Population health and care coordination evaluation plan	Annually
Complaint and grievance reporting	Semi-annual
Mental health access, pay parity, addressing childhood adversity reporting	Annually



# FY20 ACO Budget Review

# Budget Process

**18 V.S.A. § 9382** and **GMCB Rule 5.400** detail the process and criteria by which an ACO budget must be reviewed by the GMCB and includes (but not limited to) criteria that fall into these broad categories:

- Historic and future expenditures
- The effects of care models on utilization and innovative services
- The ACO's efforts to strengthen primary care, invest in social determinants of health, address the impact of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services
- Health resource allocation and priorities
- Transparency of costs
- Effects of Medicaid reimbursement on other payers
- Solvency and ability to assume financial risk
- Administrative costs
- Character of ACO leadership and competence to carry out their duties

# Budget Components

	\$ (millions)	% of Total
OneCare Vermont Aggregate Revenue	\$1,424.6	100%
LESS Provider Reimbursement	\$1,362.2	95.6%
LESS OneCare Admin Expense	\$19.3	1.4%
LESS Population Health Investments	\$43.1	3.0%
Gain/Loss	\$0	0%

# Provider Reimbursement

Provider Reimbursement Source	\$ (millions)	% of Total
Medicare	\$538.0	39.5%
Medicaid	\$282.8	20.8%
Commercial QHP	\$167.7	12.3%
Commercial Self-Funded	\$373.7	27.4%
Total	\$1,362.2	100%

*Of OneCare's 1,362.2 million-dollar value-based budget, 35% of provider reimbursements are a **fixed prospective payment** and 65% are made on a **fee-for-service** basis. OneCare is accountable for all attributed lives regardless of whether the provider opts to receive fee-for-service or a fixed prospective-based payment.*

# Hospital-ACO participation FPP%

	FY18 Actuals	FY19 Budget	FY19 Projection	FY20 Budget
Brattleboro Memorial Hospital	9.7%	11.9%	12.2%	12.5%
Central Vermont Medical Center	14.7%	23.2%	18.0%	21.8%
Copley Hospital	0.0%	0.0%	0.0%	0.0%
Gifford Medical Center	0.0%	0.0%	3.9%	5.3%
Grace Cottage Hospital	0.0%	0.0%	0.0%	0.0%
Mt. Ascutney Hospital & Health Ctr	1.4%	1.5%	12.1%	17.9%
North Country Hospital	5.2%	6.5%	6.5%	6.3%
Northeastern VT Regional Hospital	0.0%	0.0%	4.6%	5.9%
Northwestern Medical Center	14.9%	27.8%	16.9%	21.0%
Porter Medical Center	14.3%	21.7%	18.9%	23.6%
Rutland Regional Medical Center	0.0%	9.9%	3.6%	4.6%
Southwestern VT Medical Center	3.3%	4.1%	17.4%	21.2%
Springfield Hospital	0.0%	18.5%	23.0%	0.0%
The University of Vermont Medical Center	9.3%	14.8%	10.3%	16.9%
<b>System Total</b>	<b>7.5%</b>	<b>13.3%</b>	<b>10.8%</b>	<b>14.8%</b>

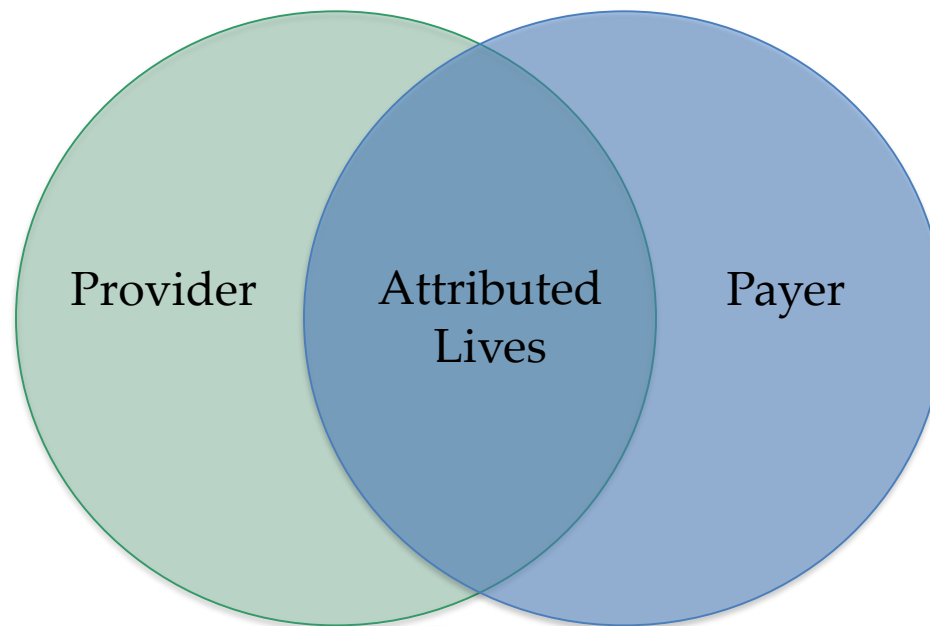
Table displays FPP as a percentage of total NPR/FPP  
Contracts for FY20 not yet executed

# Provider Reimbursement: Recommendation

1. OneCare to report annually on percentage (%) of provider payments that are Fee For Service vs. Fixed Prospective Payment by provider type (e.g. hospital, primary care – hospital, independent practice, specialist, FQHC etc.) and by payer

# Attribution = Payer x Provider

Provider reimbursements flowing through OneCare are driven by *attribution* and that population's *historical use of services*.



# Payer Programs



# Payer Programs: Disclaimer

Analyses are based solely on OCV's budget submission. GMCB staff have not yet analyzed pending or actual payer contracts. All Payer Contracts are still under negotiation.

# Payer Programs: Overview

Payer Program	Age of Program in 2020
Medicare ACO Initiative	3 <sup>rd</sup> year
Medicaid NextGen ACO	4 <sup>th</sup> year
BCBS QHP	3 <sup>rd</sup> year
BCBS ASO/Large Group	New
MVP QHP	New

# Payer Programs: APM & Scale

**To qualify as a Scale Target ACO Initiative under the APM a program must meet the following requirements:**

1. Possibility of Shared Savings for achieving goals related to quality of care or utilization.
2. The ACO's Shared savings, as a percentage of its expenditures less than the benchmark, is at minimum 30%; if the ACO is also at risk for Shared Losses, its Shared Losses, as a percentage of its expenditures in excess of the benchmark, is at minimum 30%.
3. Services comparable to, but not limited to, the All-Payer Financial Target Services and their associated expenditures are included for determination of the ACO's Shared Losses and Shared Savings;
4. The ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both.

# Payer Programs: APM & Scale

## 1. Existing Programs

OneCare expects all existing programs to continue to be qualified as Scale Target ACO Initiatives.

## 2. New Programs

OneCare expects all new programs to qualify as Scale Target ACO Initiatives.

# Payer Programs: APM & Alignment

The APM Agreement requires that programs reasonably align with the Vermont Medicare Next Generation Initiative in the areas of...

1. Alignment/attribution methodologies
2. Quality measures
3. Payment mechanisms
4. Services included in determining shared savings and losses.

# Payer Programs: APM & Alignment\*

	Medicare	Medicaid	BCBS QHP	BCBS ASO/Large Group	MVP
Attribution	PCP/claims-based	PCP/claims-based & geo	PCP/claims-based	TBD	TBD
Quality	13 measures	10 aligned measures	10 aligned measures**	TBD	TBD
Payment	FPP	FPP	FPP (pilot) & FFS	TBD	TBD
Risk	Two-sided; 95%-105%	Two-sided; 96%-104%; geo TBD	Two-sided; 94%-106%	TBD	TBD
Services Incl. in Fin Targets	Inpatient, Outpatient, etc.	Aligned	Aligned	TBD	TBD

\*Projected by OCV as of 10/01/2019 Budget Submission, payer contracts still under negotiation

\*\*Two of BCBS's QHP aligned measures are "composite measures" and 1 aligned measure

# Payer Programs: Budgeted PMPM\*

Payer	Current Year Projections (2019)		Budget Year (2020)				(G) Expected Growth Trend = E/A - 1
	(A) PMPM	(B) Member Months	(C) Base experience PMPM	(D) Trend Rate	(E) Budgeted PMPM = C x D	(F) Budgeted Member Months	
Medicare **	\$836.35	622,804	\$830.15	3.90%	<b>\$862.53</b>	623,699	<b>3.1%</b>
Medicaid	\$266.51	817,986	\$266.51	0.50%	<b>\$267.84</b>	1,056,029	<b>0.5%</b>
Commercial - QHP ***	\$584.85	218,254	\$490.52	6.04%	<b>\$520.14</b>	393,117	<b>-11.1%</b>
Commercial - Self-Funded ***	TBD	TBD	\$464.07	4.05%	<b>\$482.86</b>	774,019	<b>0.0%</b>
Total	\$523.12	1,659,044	\$474.61	3.54%	<b>\$491.40</b>	2,846,864	<b>-6.1%</b>

\*Projected by OCV as of 10/01/2019 Budget Submission, payer contracts still under negotiation

\*\* Claims spend only – no shared savings carry-forward component added

\*\*\* Spend numbers are the allowed amounts to provide a stable comparison between years

- (A) Projected PMPM cost through PY, excluding shared saving/loss estimates and other non-claims-based payments (e.g. care coord./admin)
- (B) Projected MM through PY, incorporating expected attrition for future months.
- (C) The base experience used to build the current budgeted rate.
- (D) Trend rate, may be for multiple years.
- (E) The targeted PMPM being used for each program for the budget (calculated).
- (F) The estimated MM for the upcoming PY, including assumptions related to attrition.
- (G) Comparison between the projected experience in the current PY and the budgeted PMPM cost.

# Payer Programs: Unpacking the Trend Rates

**Medicare:** GMCB is recommending 3.5% growth in setting the benchmark – potential vote on December 18

**Medicaid:** 2018 actuals  $\times [\Delta 2018 \text{ to } 2019 \text{ YTD (2.2\%)}] \times [2019 \text{ to } 2020 (0.5\%)]$

- Does not take into account repricing, which is held harmless under APM
- Subject to Medicaid advisory rate case (pending)

**Commercial QHP:** Derived from GMCB approval rates

**Commercial Self-Funded:** TBD



# Payer Programs: Recommendations

2. OCV to provide final payer contracts upon signature
  1. Final payer contracts must...
    1. Qualify as scale target initiative, otherwise OCV to justify to the Board
    2. Align with Medicare on attribution methodology, quality metrics, payment and risk terms, and services included in financial targets; and inline with the 2019 budget order, OCV must justify any material differences between programs
3. OCV to come before the Board on a date agreed upon by both parties but no later than April 1, 2020 to present final attribution, revised 2020 budget, and final payer contracts
4. OCV to create a one-pager on the benefits to self-funded programs of contracting with OCV
5. If geographic attribution is implemented in the Medicaid program, OCV to provide implementation manual

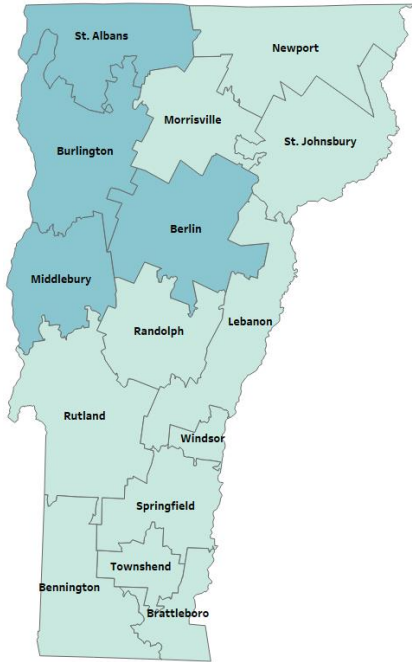
# Payer Program: Recommendations

## 6. Trend Rates

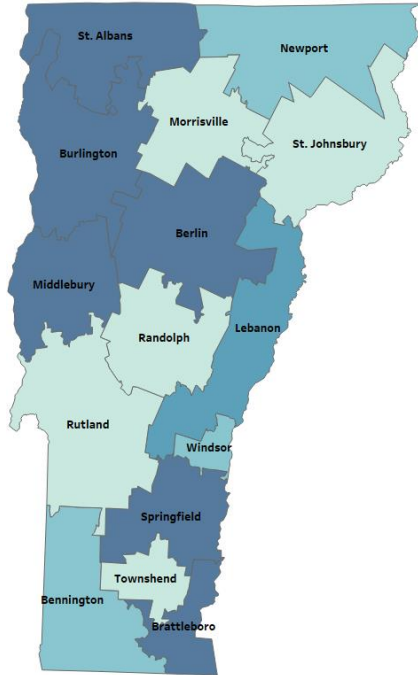
- Medicare – staff recommendation of 3.5%, potential vote on December 18, 2019
- Medicaid – recommendation to adopt % within Wakely range, upon Medicaid Advisory Rate Case
- Commercial (QHP and Self-Funded) – As in FY 2019 OCV to provide the Board with...
  - Actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive
  - An explanation of how its overall rate of growth across all payers fits within the overall all-payer target rate of growth and, if its overall rate of growth exceeds the target, how it plans to achieve the cumulative target for the term of APM Agreement (2017 to 2022)

# Provider Network

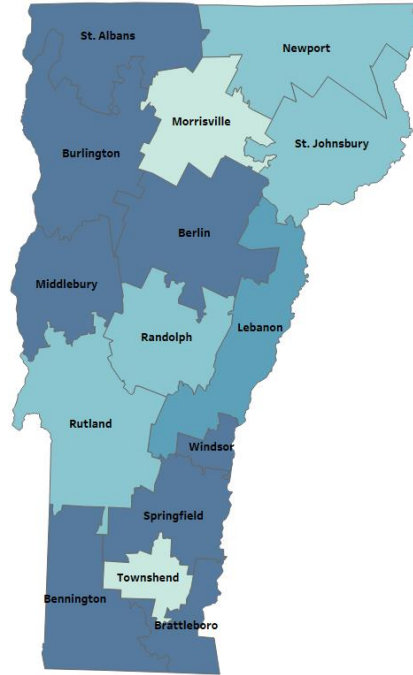
2017



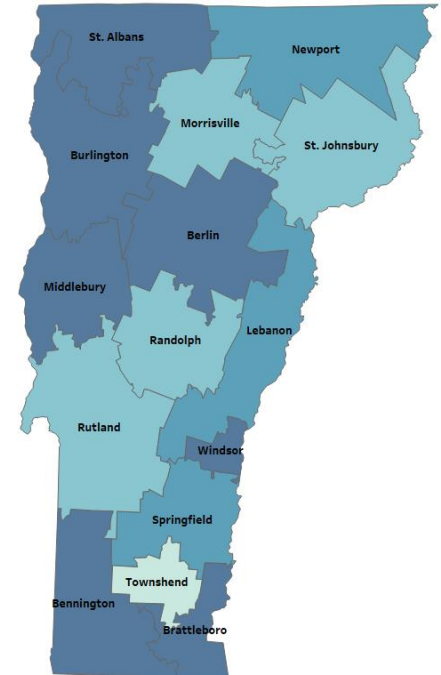
2018



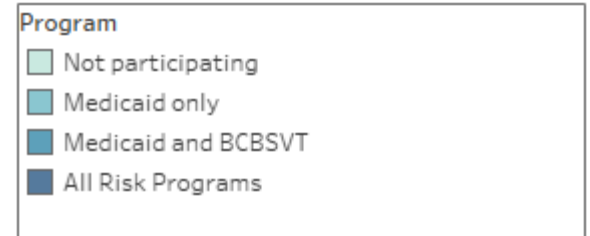
2019



2020



# OneCare Hospital Service Area Participation 2017-2020



Link to Tableau Public Visualization:  
[https://public.tableau.com/profile/state.of.vermont#!/vizhome/OCVNetworkParticipation\\_FY20/Dashboard1](https://public.tableau.com/profile/state.of.vermont#!/vizhome/OCVNetworkParticipation_FY20/Dashboard1)

# OneCare Provider Network: 2019 to 2020 Changes

## *Expanded network*

- Morrisville HSA (Copley) in for VMNG
- Newport HSA (North Country) and CHCB added BCBSVT QHP participation
- 1 new HSA and hospital (Copley), 3 FQHCs, 3 independent PCP practices, 1 naturopath, 3 independent specialists, 4 independent PT practices, 1 designated MH agency, 3 SNFs, 1 ASC\*

## *Reduced network*

- Springfield not participating in Medicare FY20 (all programs in FY19)
- 1 PCP, 5 specialist practices\*\*

## *Challenges\**

- Expansion into Medicare program due to magnitude of downside risk and operational concerns
- Recruitment of independent specialists due to lack of eligibility for incentives in Medicare Merit-based Incentive Payment System (MIPS)

\*OneCare FY20 Budget submission, Section 2

\*\*GMCB analysis of Sheet 2.1 Provider Network from submission, Year-Over-Year

# OneCare 2020 Provider Network

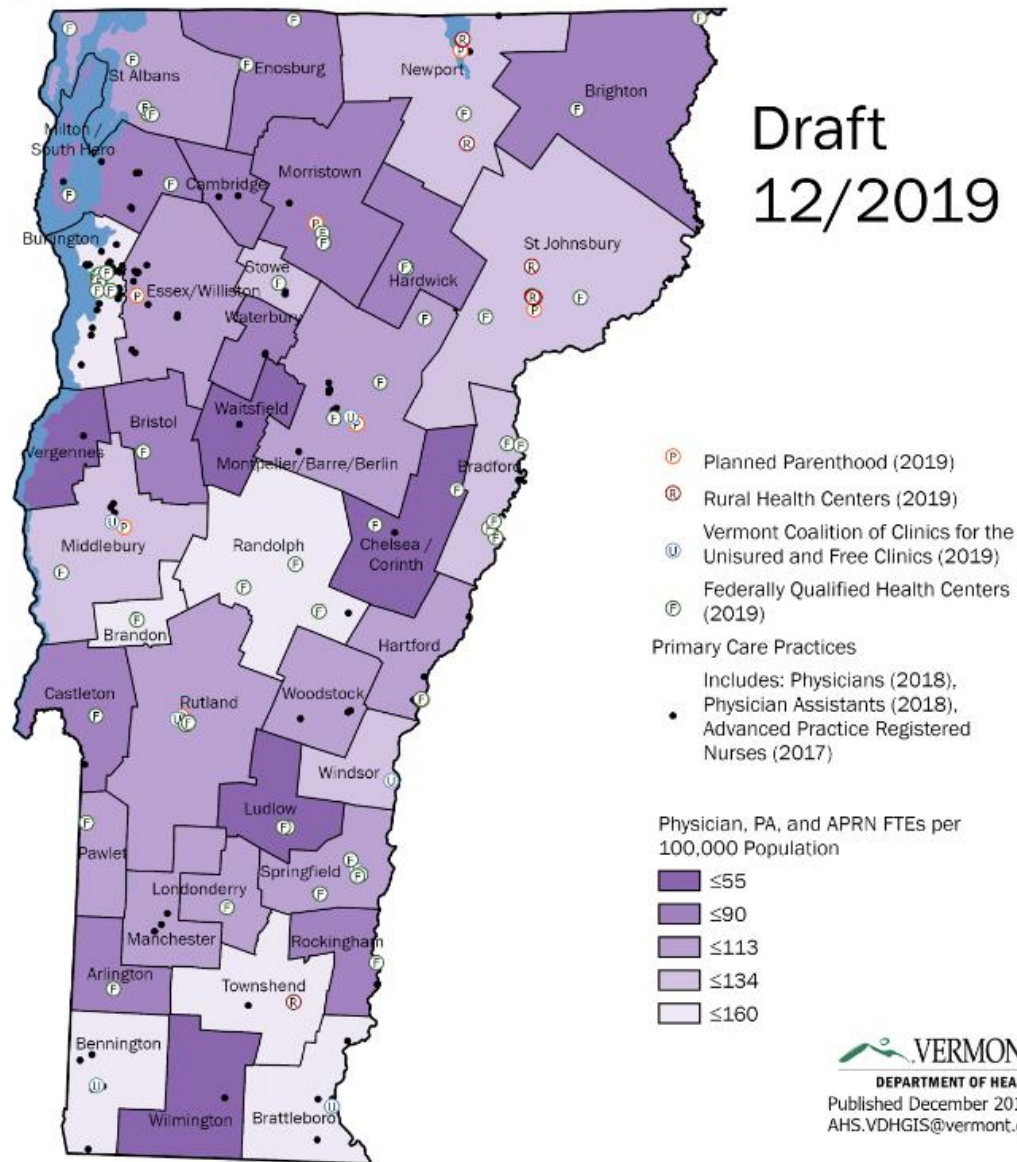
Provider Type	2019 Participation ~N of total provider type in VT	2020 Participation ~N of total provider type in VT
Hospitals and hospital providers (primary care and specialists)	<b>12 of 14 hospitals</b> Copley and Grace Cottage out <b>1 in NH</b> Dartmouth	<b>13 of 14 VT hospitals</b> Copley in <b>1 in NH</b> Dartmouth
Federally Qualified Health Centers (FQHCs)	<b>6 of 12 entities</b> including CHCB, NOTCH, SMCS, Gifford, CHCRR, Northern Counties	<b>9 of 12 entities</b> 3 new: NE Washington County (Berlin), Five Town Health Alliance (Middlebury), Copley (Morrisville)
Primary Care Practices (~approximations) Hospital Independent FQHCs	<b>~267 total practices</b> (VDH data) <b>~73 practices</b> (hosp. provider directories) <b>~24 of ?#</b> <b>~# out of 54 sites</b> (VDH data)	<b>~267 total practices</b> (VDH data) <b>~76 practices</b> (hosp. provider directories) <b>~29 of ?#</b> 5 new, incl. naturopath <b>~49 out of 54 sites</b> (VDH data)
Independent specialist	<b>22 of ?#</b>	<b>25 of ?#</b> 3 new: arthritis/rheumatology, breast surgery, urology
Home health and hospice	<b>9 of 9</b>	<b>9 of 9</b>
Skilled nursing facilities (SNFs)	<b>23 of 38</b>	<b>27 of 38</b>
Designated mental health agencies (DAs) & specialized service agencies	<b>9 of 16</b>	<b>10 of 16</b> Lamoille County new
Other (physical therapy, ambulatory surgical center)	<b>1 of #</b>	<b>6 of #</b> 4 PTs, 1 ASC

# OneCare 2020 Provider Network

Provider Type	Which Health Service Areas <u>do not</u> have any of these provider types listed?
Hospitals and hospital providers (primary care and specialists)	Townshend (Grace Cottage)
Federally Qualified Health Centers (FQHCs)	<ul style="list-style-type: none"><li>• Bennington (Battenkill Health)</li><li>• Newport (Indian Stream)</li><li>• Windsor (Little Rivers Health Care--consider Grace Cottage their home hospital)</li><li>• Brattleboro (no FQHC)</li></ul>
Primary Care Practices Hospital Independent FQHCs	Hosp: Townshend Ind: Berlin, Newport, Springfield, Randolph, St. Johnsbury, Townshend
Independent specialist	Brattleboro, Windsor, Springfield, Randolph, Rutland, St. Johnsbury
Home health and hospice	None – all communities in network
Skilled nursing facilities (SNFs)	Lebanon, Randolph
Designated mental health agencies (DAs) & specialized service agencies	None – all communities have at least 1 DA in network
Other (physical therapy, ambulatory surgical center)	Windsor, Newport, Morrisville, St. Johnsbury



## Primary Care by Rational Service Area



GMCB is working in collaboration with the VT Department of Health to quantify and map the provider landscape as part of the Health Resource Allocation Plan project.

Source: Vermont Department of Health: Health Care Provider Census (2017, 2018); B-State Association: Safety Net Provider List (2019)

Rational Service Areas (RSAs) are designed based on where people receive primary care and where they live, as determined from data from Medicare, Medicaid and the Vermont Behavioral Risk Factor Surveillance System. In Vermont, primary care and dental care are divided into 38 separate RSAs.

FTE ratios only includes providers in locations open to the public. Facilities that do not offer outpatient services, do not offer on-site services, or are urgent care clinics are excluded. Locum tenens providers are excluded. Locations include independent practices, hospital owned practices, and group practices.



# Provider Network: Recommendations

7. OneCare to submit a 2021 Network Development Strategy that includes the following elements:
  - A definition for ACO “network composition” necessary to maximize value-based incentives
  - Provider outreach strategy
  - Provider recruitment and acceptance criteria
  - Network development timeline
  - Providers dropping out of the network (quantify) and reasons why
  - Challenges to network development

# Scale

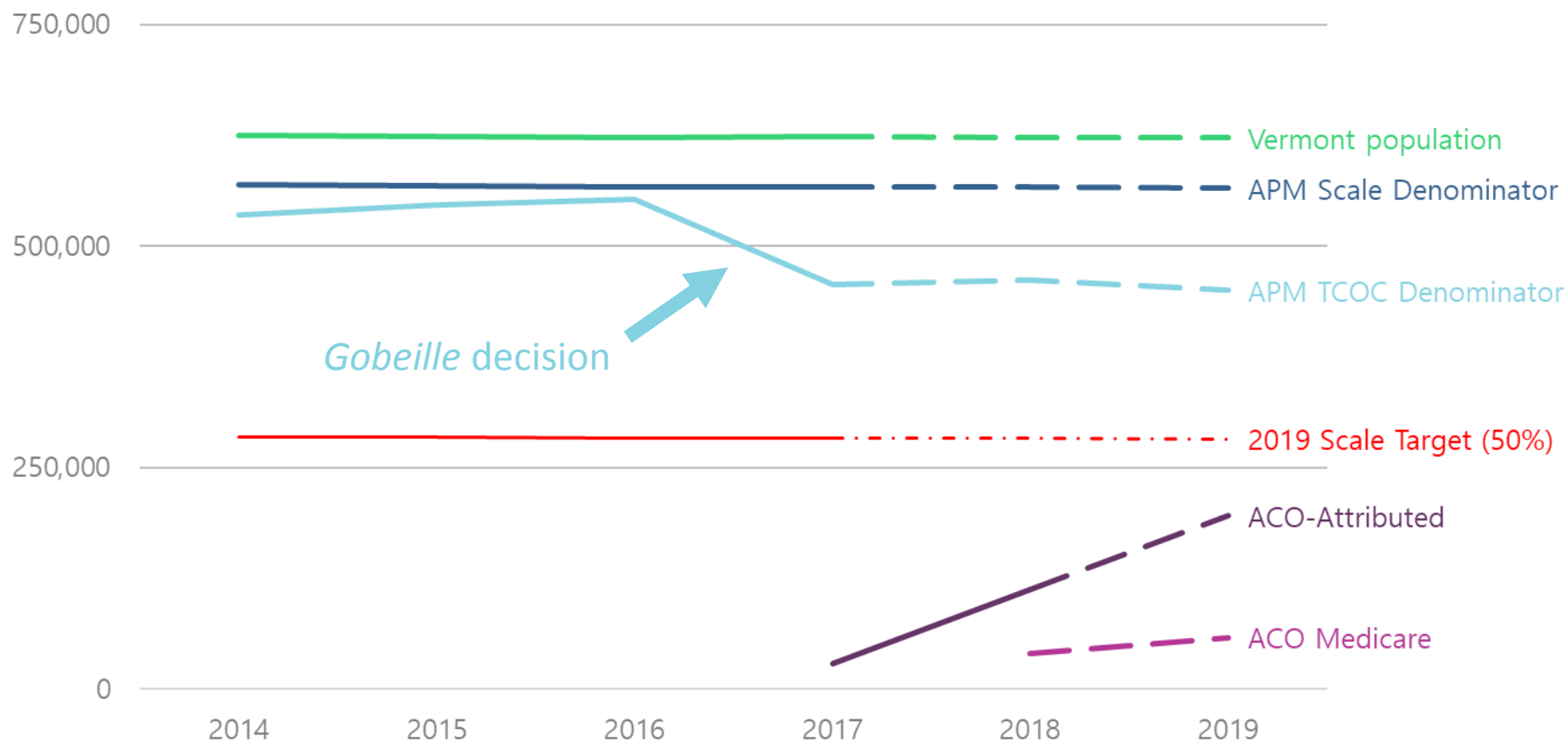
# Scale: Payer Program x Provider

## What is “Scale”?

- Percentage (%) of Vermonters attributed to a Scale Target ACO Initiative
- Designed to ensure that a critical mass of Vermont’s population is engaged in the APM– and hence, that providers have a real opportunity to change their care delivery and business models to support value, not volume and a migration from treating episodic illness to prevention.

Scale Targets per APM Agreement	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
All-Payer Scale Target	36%	50%	58%	62%	70%
Medicare Scale Target	60%	75%	79%	83%	90%

# Scale and APM Populations



# Model Agreement Requirements: Preliminary Scale *Estimates*

	2018 Final			2019 Projected			2020 as Submitted (Budget)		
	APM Population	Population In Scale Target Initiatives	Scale Performance (Target)	APM Population	Population In Scale Target Initiatives	Scale Performance (Target)	APM Population	Population In Scale Target Initiatives	Scale Performance (Target)
<b>Medicare</b>	<b>115,029</b>	<b>39,702</b>	<b>36% (60%)</b>	<b>113,272</b>	<b>54,210</b>	<b>48% (75%)</b>	<b>~114,080</b>	<b>~53,014</b>	<b>~46% (79%)</b>
Medicaid	136,407	42,342		135,879	75,711		~130,025	~94,221	
Commercial Self-Funded	182,151	9,874		166,996	10,111		~171,795	~66,387	
Commercial Fully Insured	105,473	20,838		92,978	20,074		~88,083	~35,842	
Commercial Medicare Advantage	11,749	0		12,693	0		~17,776	0	
<b>All-Payer Total</b>	<b>550,809</b>	<b>112,756</b>	<b>20% (35%)</b>	<b>521,818</b>	<b>160,106</b>	<b>31% (50%)</b>	<b>~521,759</b>	<b>~249,464</b>	<b>~48% (58%)</b>

# Scale Target Memo

In response to not meeting scale targets in the first year of the model, state partners conducted a survey over the summer.

Vermont hospitals and FQHCs identified barriers to scale and potential strategies for state, federal, ACO, and local partners to improve the model. Strategies fell into two broad categories:

1. Payment structure should be more *transparent, predictable, and sustainable*
2. Payments from the ACO and participating payers must offset additional administrative and reporting requirements (*reduce burden*) and incentivize delivery reform, with a greater emphasis on prevention and health improvement (*incentivize population health*).

# Scale Target Memo

Examples of scale strategies identified for OneCare to pursue include:

- Design an option for primary care to join without a hospital partner
- Offer multiple risk models based on hospital size and readiness
- Improve clarity of contracts with FQHCs (e.g., expectations, deliverables, attribution methodology)
- Offer or facilitate network-based telehealth opportunities to smaller providers
- Continue to improve Care Navigator to allow use for all patients (not just ACO-attributed) and reduce burden of duplicate record-keeping by allowing uploads from existing EMR systems

Source: <https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/GMCB%20Scale%20Memo%208-15-2019.pdf>

# Scale: Recommendations

8. OCV to report formally on status of their Scale Target Memo follow-up items during presentation on final attribution, revised budget etc.



# Model of Care and Population Health Investments

# Vermont's 2017 Population Health Plan

FIG. 5: Vermont Health Care Delivery System Evolution

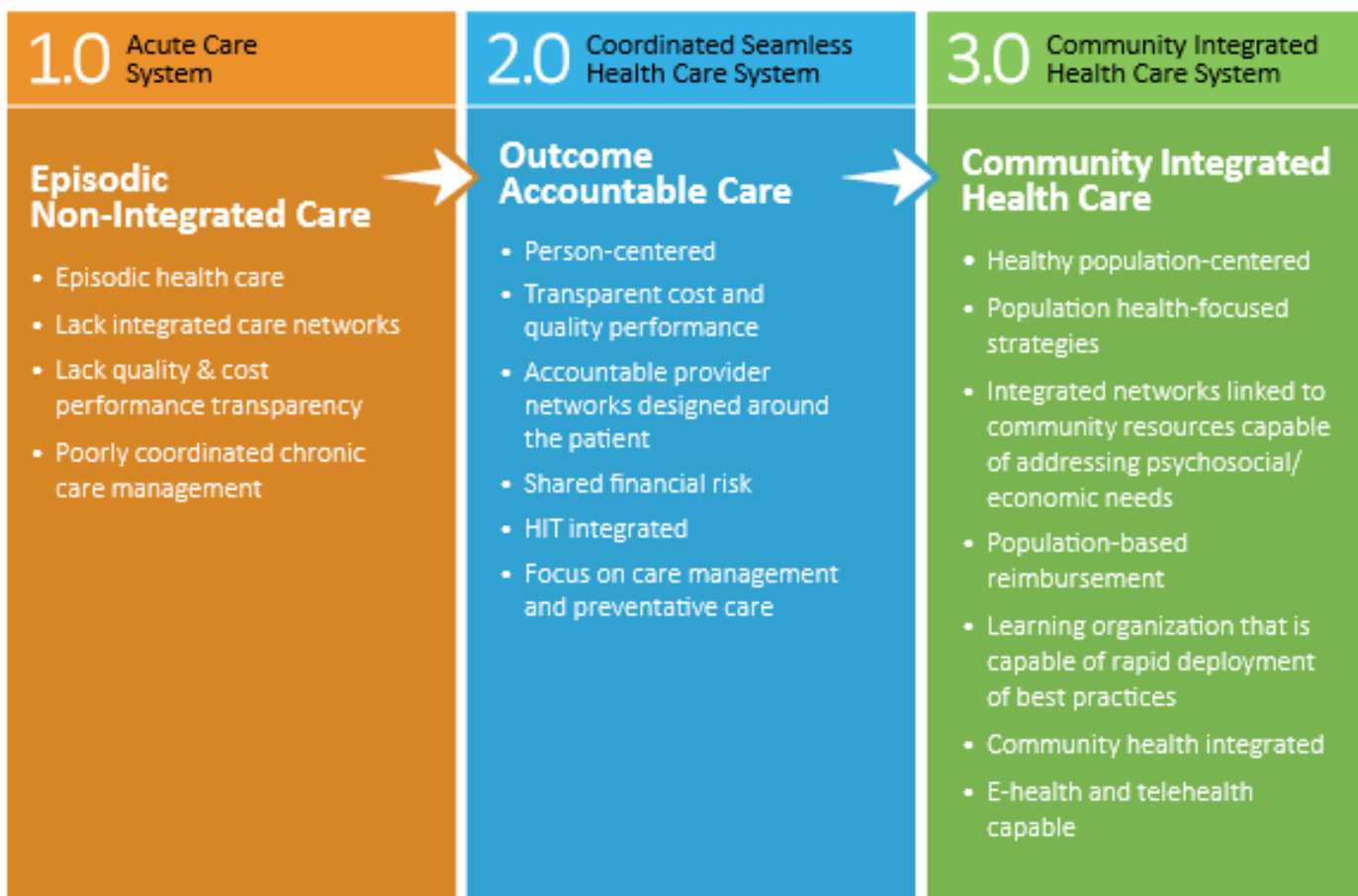


Figure 5, page 19: <https://healthcareinnovation.vermont.gov/sites/vhcup/files/documents/SIM-PopulationHealthPlan-Final-Web.pdf>



# Where does the ACO fit into Vermont Population Health

Figure 3 page, 19:

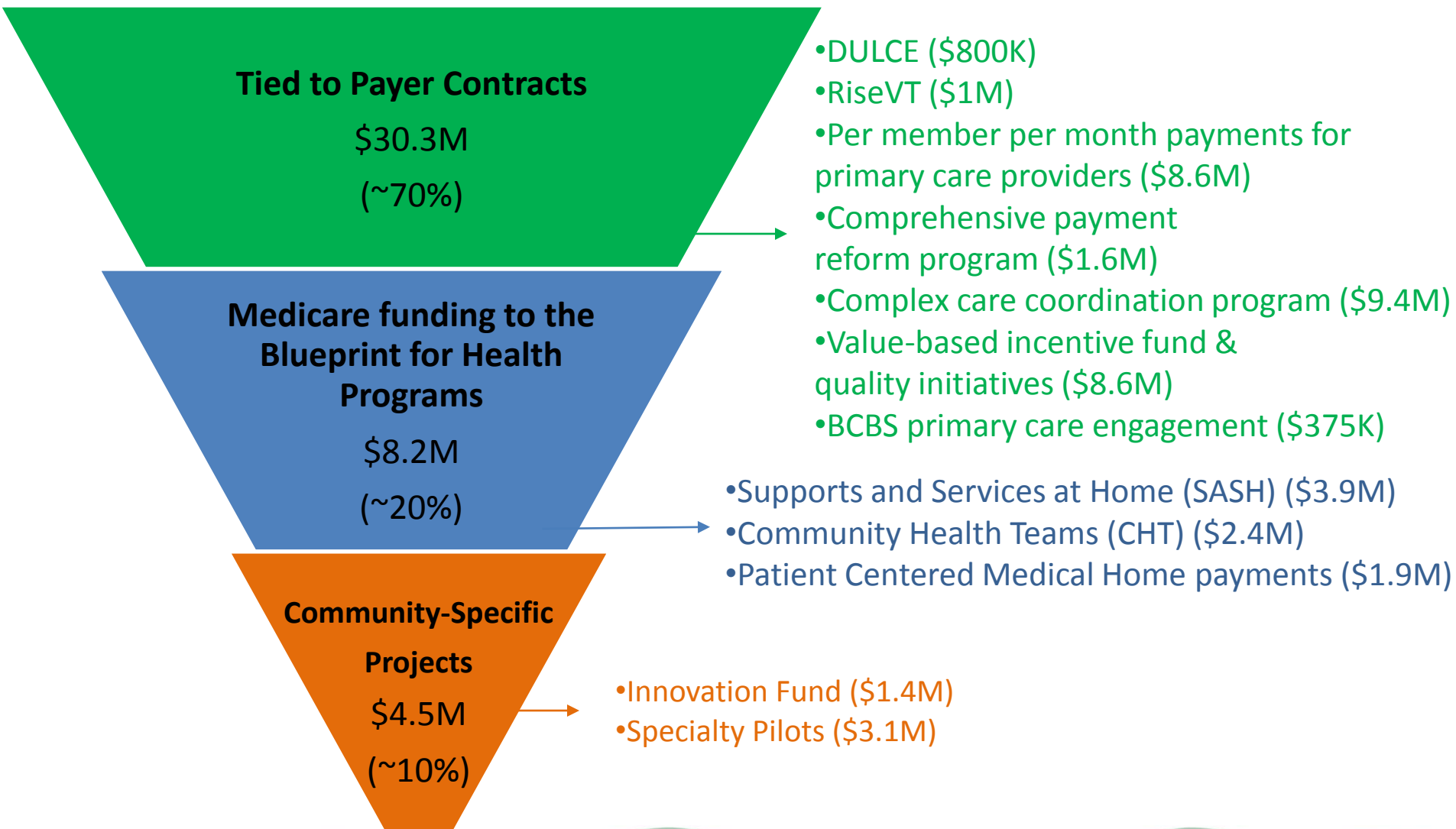
<https://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/SIM-PopulationHealthPlan-Final-Web.pdf>

# OneCare's role

To work with a statewide network of providers to increase access and quality of care while reducing unnecessary costs

Model of Care	Examples of work
ACO supports statewide care transformation and payment reform activities at the local level	<ul style="list-style-type: none"><li>• Coordinating with the Blueprint for Health's Community Collaboratives to identify gaps in care and perform quality analyses for communities</li><li>• Compiling, analyzing, and providing claims data for community collaboratives and providers to identify variations in cost, utilization, and quality</li><li>• Providing Care Navigator, data collection tools, and toolkits to support Care Coordination</li><li>• Aligning value-based payer contracts</li><li>• Managing a fixed payment methodology</li></ul>
Value based payments and community-based new initiatives for population health	<ul style="list-style-type: none"><li>• Payments to support daily efforts in primary care and care coordination</li><li>• Funding new innovations, with outcomes being measured, for potential replicability to impact community wellness</li></ul>

# Population Health Areas of Investments



# Population Health Investments

Category of Investment	Budget Line Item	2020 Budget
Primary Care	Basic OCV Per Member Per Month	\$8,569,920
Primary Care	Comprehensive Payment Reform Program	\$1,606,613
Primary Care	Primary Care Engagement Investment	\$375,000
Quality	Value-Based Incentive Fund (VBIF) for 2020	\$8,387,232
Quality	VBIF Quality Initiatives	\$167,505
Care Coordination	Complex Care Coordination Program	\$9,423,590
Care Coordination	DULCE	\$800,000
Primary Prevention	RiseVT	\$1,031,752
Blueprint for Health funding	Patient Centered Medical Home (PCMH) Payments	\$1,894,417
Blueprint for Health funding	Community Health Teams Block Payment	\$2,379,711
Blueprint for Health funding	Supports and Services at Home (SASH)	\$3,968,246
Specialty Care and Mental Health	Specialist Program Pilots	\$3,144,500
Innovation	Innovation Funds	\$1,367,580
	<b>Total</b>	<b>\$43,116,066</b>

# 2020 Changes to Population Health Programs

Additional innovation projects

- Determined through their grant process

New specialty pilot(s)

- Embedded clinical pharmacists in primary care

Changes to the statewide complex care coordination program

- Increasing per member per month payments

# Complex Care Coordination Program Payment Structure Changes

Participants in the Complex Care Coordination Program: providers from existing primary care, home health, and Designated Agencies

## 2017-2019

### 1. Care Coordination

- \$15.00 per adult attributed life per month
- Distributed upon providers meeting deliverable criteria laid out in OneCare Vermont provider participation agreement (see Appendix or contract for requirements)

### Patient Activation

- \$150.00 once a year and \$10 per adult attributed life per month
- Distributed once a patient has been engaged and has an activated shared care plan entered into Care Navigator

## 2020\*

### 1. Lead Care Coordinator

- \$80.00 per adult attributed life per month: effective the month the Lead Care Coordinator and Shared Care Plan are designated in Care Navigator
- \$60.00 per adult attributed life per month: effective the month the Care Team member and Shared Care Plan are designated in Care Navigator

### 2. Care Conference

- Lead Care Coordinator - \$300.00 paid once per year after a qualifying care conference is documented in Care Navigator
- Care Team - \$150.00 paid once per year after an eligible provider participates in the Care Team and in the care conference for the attributed life

\*As listed in the OneCare Vermont Participation Agreement for returning ACO participants: to begin in April 2020

<https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/Part%202020Attachment%20E%20-Provider%20Contracts%20and%20Addendums.pdf>



# Population Health Ratio (PHM Ratio)

Metric	2018 Budget	2018 Actual	2019 Budget	2019 Projected	2020 Budget
Total Revenue	\$639 M	\$634 M	\$899 M	\$882 M*	\$1,425 M
Pop Health Mgt (PHM) Total	\$27 M	\$23 M	\$37 M	\$36 M	\$43 M
Blueprint	\$7.8 M	\$7.8 M	\$8.1 M	\$8.0 M	\$8.2 M
(PHM LESS Blueprint)/Revenues	3.05%	2.40%	3.25%	3.10%	2.45%
PHM/Total Revenues	4.27%	3.63%	4.14%	4.03%	3.03%

*\*Commercial Self-Funded data pending, excluded from projected but budgeted at \$65 M*

# PHM Ratio: FY 2019 Budget Order

*OneCare must fund the PHM and payment reform programs/investments described in its submission at **no less than 3.6% of its overall budget** (i.e., within 0.5 percentage points of the targeted ratio of 4.1%) and **must fund the SASH and Blueprint for Health (PCMH and CHT) investments at 2018 Medicare levels plus an inflationary rate of 3.8% in risk and non-risk communities.** If the percentages are projected to be less than those required by this order by the end of 2019, OneCare must promptly alert the Board.*

# PHM Ratio: Next Steps

Insufficient information at this time to provide a high-quality recommendation for OneCare's required PHM ratio, thus we recommend the next steps:

1. GMCB to receive final payer contracts
2. GMCB to receive final attribution numbers
3. OCV to provide GMCB with an analysis for each PHM line item as to whether and why such is appropriately scaled by attribution, or some other factor.
4. GMCB to receive revised budget

# Population Health: Recommendations

9. If Population Health Management (PHM) Programs are not fully funded as detailed in OneCare Vermont's 2020 budget, OneCare Vermont will put forth a revised proposal to the Board.
10. PHM investments shall report by HSA quarterly, by program, and by provider type.
11. OneCare Vermont will use their community-specific population health investments (innovation fund and specialty pilots) to address cost and quality differences across Health Service Areas as identified in their variations in care analysis. These investments shall be evidence based, be assessed for return on investment, and be tracked by the ACO.
12. OneCare Vermont shall develop a workplan to evaluate the effectiveness of any population health investment, including analysis for how to scale those that are successful, sunset those that are not and report on opportunities for sustainability. This plan could include but not be limited to the entity, funding amount, evidence for funding, distribution plan for funding, scope of project, timeframe, measurable outcomes, and risk/issues/challenges. The analysis should be submitted to the GMCB in the first quarter of 2020.
13. OneCare Vermont shall provide a mid-year update on the 2020 complex care coordination program to include data on enrollment, payments, and any challenges or learning opportunities.

# Quality

# Quality: Agreement Requirements

- The APM Agreement states that it aims not only to control the rate of growth in health care costs but to maintain health care quality in Vermont
- Annual Quality Report must include:
  - 1) progress on quality targets;
  - 2) *how scale target ACO Initiatives hold Vermont ACO's accountable* for quality of care, the health of their aligned beneficiaries, or both; and
  - 3) *how the state holds Vermont ACOs accountable* to allocate funding for and invest in community health services to achieve Statewide Health Outcomes and Quality of Care Targets.

# Quality: Rule 5.000 Requirements

- Rule 5.000 Requirements
  - 5.205(b) **Provider Network:** ...The ACO's Participant selection criteria *must relate to the needs of the ACO and Enrollee population it serves, including access to and Quality of Care.*
  - 5.206(a) **Population Health Management and Care Coordination:** A *primary function of an ACO is to improve Enrollees' Quality of Care* by enhancing coordination and management of the services Enrollees receive.
  - 5.207 (a-d) **Quality Evaluation and Improvement:** Requires an ACO to have a quality and evaluation improvement program that *identifies problems in health care delivery and opportunities for improvement; evaluates the care delivered to patients against defined measures and standards; must utilize evaluations to provide feedback to participants to improve quality of care.*

# Quality

1. ACO 2018 results were presented on 11/20/2018; will continue annually
2. APM 2018 results will be presented by GMCB staff when available



# Quality: Next Steps

1. GMCB staff to analyze ACO quality performance, once APM results become available
2. GMCB Staff to develop policy for ACO regulation on quality performance, in alignment with the APM requirements

# Administrative Expenses

# OneCare Administrative Expenses

Expense Category	\$ (millions)	% of Total
Salaries and Benefits	\$11.8	61.1%
Software	\$3.7	19.3%
Contracted Services	\$1.2	6.1%
Reinsurance/Risk Protection	\$1.1	5.6%
Other (incl. travel, PD, meetings)	\$0.7	3.8%
Occupancy	\$0.5	2.4%
Supplies	\$0.2	1.0%
Insurance/Risk Protection	\$0.2	0.8%
Total	\$19.3	100%

# Administrative Expense Ratio

## Administrative Expense Ratio Calculation:

$$\frac{ACO \text{ Operational Expenses}}{ACO \text{ Total Revenue}}$$

*Operational Expenses: includes salary, benefits, contracts, supplies etc.; does not include population health investments, provider reimbursements (“existing health care spending”)*

# Administrative Expense Ratio

Metric	2018 Actual	2019 Budget	2019 Projected	2020 Budget
Total Revenue	\$634 M	\$899 M	\$882 M*	\$1,425 M
Admin Expense	\$11.7 M	\$15.9 M	\$15.2 M	\$19.3 M
<b>Admin Expense Ratio</b>	<b>1.84%</b>	<b>1.77%</b>	<b>1.72%</b>	<b>1.35%</b>

*Though OCV's administrative expense is increasing in aggregate over their prior year budget (21%), relative to program growth, the administrative expense ratio is expected to decrease based on OCV's submitted budget.*

# Administrative Expense Ratio

	Low Growth	High Growth	OCV Budget
Admin Exp Ratio	1.60%	1.28%	1.35%
Assumptions	<ul style="list-style-type: none"> <li>No award of DSR/IAPD \$</li> <li>↓ in attribution (15% x payers)                             <ul style="list-style-type: none"> <li>Medicare (6%)</li> <li>Medicaid (6%)</li> <li>Commercial-QHP (6%)</li> <li>Self-Insured (40%)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Awarded DSR/IAPD \$</li> <li>↑ in attribution (3% x payers)                             <ul style="list-style-type: none"> <li>Medicare (15%)</li> <li>Medicaid (OCV budget)</li> <li>Commercial-QHP (OCV budget)</li> <li>Self-Insured (OCV- budget)</li> </ul> </li> </ul>	

*Adopting a conservative approach, changes in attribution and access to DSR funding is unlikely to cause huge swings in the administrative expense ratio.*

# Administrative Expense: Recommendations

14. If total revenues are projected to increase, the administrative expense ratio shall not exceed 1.35%, and if total revenues are projected to decrease, the administrative expenses ratio shall not exceed 1.60%, unless otherwise approved by the Board. The Board will review this condition based on final attribution.

# Risk and Reserves



# Transferring Performance Risk to Providers



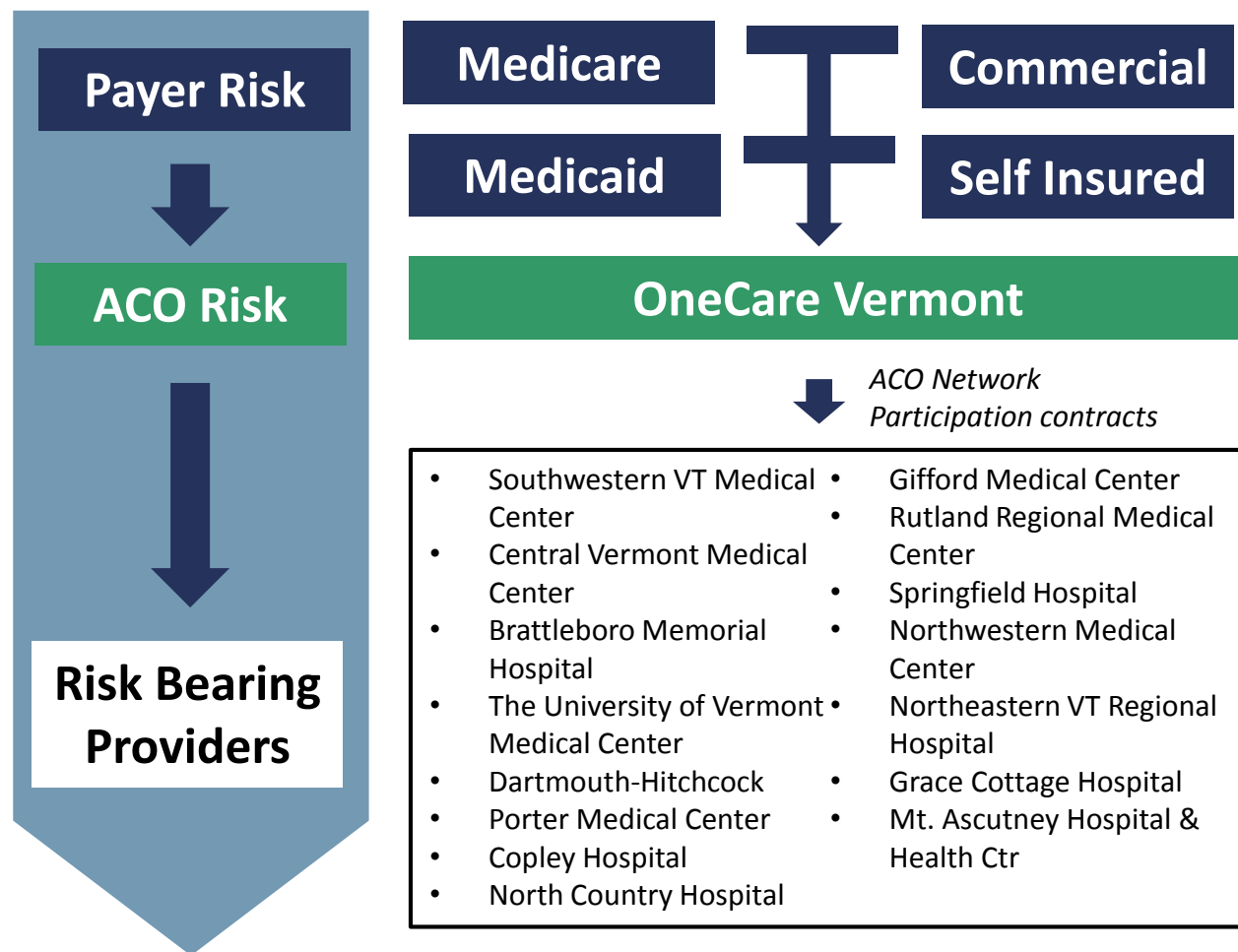
**Insurance Risk:** Financial risk that is based on the prevalence, severity, and types of health conditions that occur in a population



**Performance Risk:** Financial risk based on what is done to mitigate health conditions, which is a function of the number and type of treatments that are applied

**Key Takeaway:** While there is overlap of performance risk with insurance risk, some performance risk still can be measured and transferred to providers.

# Transferring Performance Risk to Providers



**Key Takeaway:**  
Vermont payers transfer a percentage of financial risk onto OneCare Vermont, which then transfers this risk onto hospitals participating in the OneCare network.

# OneCare 2020 Risk by Payer

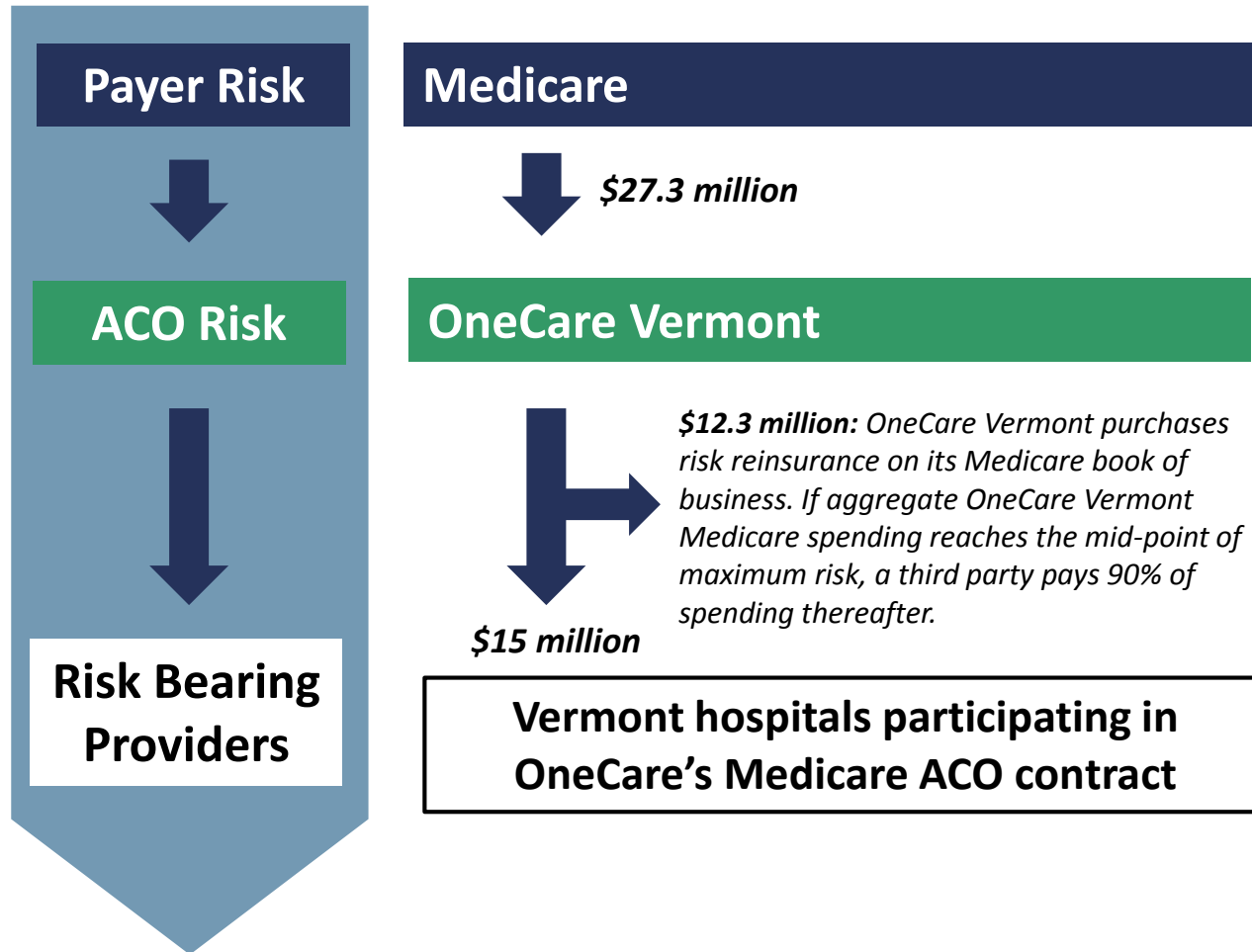
Payer	Projected Spending	At Risk	% At Risk by Payer
Medicare	\$546.2 M	\$27.3 M	5.0%
Medicaid	\$282.8 M	\$11.3 M	4.0%
Commercial-QHP	\$167.7 M	\$3.6 M	2.2%
Self Insured	\$373.7 M	\$1.9 M	0.5%
<b>TOTAL</b>	<b>\$1,370.5 M</b>	<b>\$44.1 M</b>	<b>3.2%</b>

**Note:** Dollars in \$1,000s.

**Source:** OCV 2020 Budget Submission

**Key Takeaway:** The percentage of financial risk transferred to OneCare varies by payer. As a percentage of total health care spending, payers transfer approximately 3.2% of all-payer aggregated financial risk onto OneCare Vermont. The remaining risk resides with each individual payer.

# Impact of OneCare's Medicare Risk Reinsurance



## Key Takeaway:

Of the \$27.3 million (5% of Medicare expenditures) that OneCare projects at risk in 2020, the maximum risk faced by OneCare's Medicare participating hospitals (in aggregate) would be approximately \$15 million (2.8% of Medicare spending) due to third party risk reinsurance.

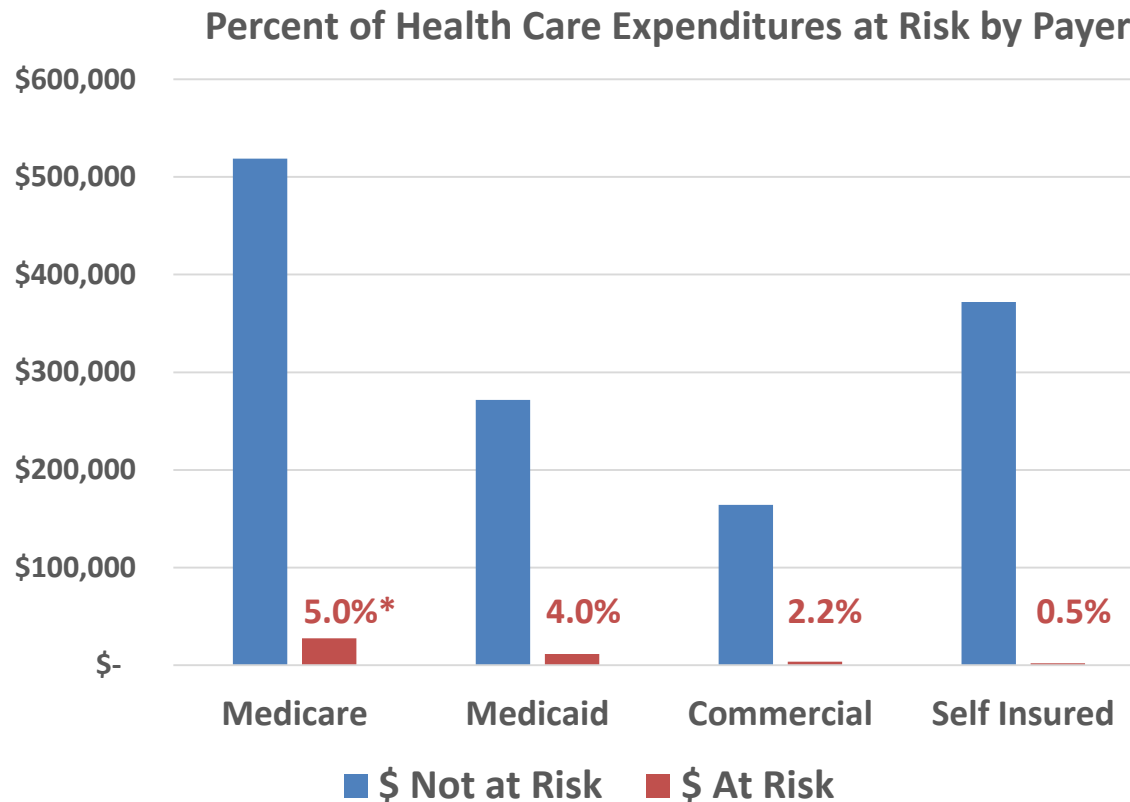
# OneCare 2020 Revenue and Risk by Payer

(After accounting for OneCare's Medicare Risk Re-insurance)

Payer	Projected Revenue	At Risk	% At Risk by Payer
Medicare	\$546.2 M	\$15.0 M	2.8%
Medicaid	\$282.8 M	\$11.3 M	4.0%
Commercial-QHP	\$167.7 M	\$3.6 M	2.2%
Self Insured	\$373.7 M	\$1.9 M	0.5%
<b>TOTAL</b>	<b>\$1,370.5 M</b>	<b>\$31.8 M</b>	<b>2.3%</b>

**Key Takeaway:** After accounting for the impact of OneCare's Medicare risk reinsurance, the aggregate financial risk of the OneCare network is projected to be approximately 2.3% of all-payer health care expenditures.

# OneCare Projected 2020 Health Care Expenditures and Dollars at Risk by Payer



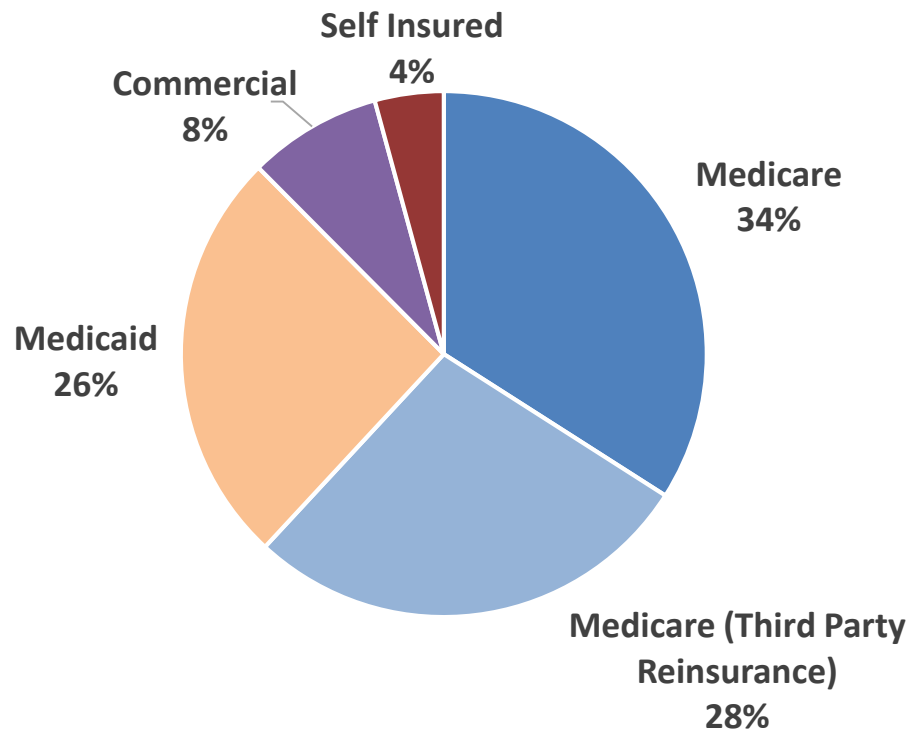
## Key Takeaway:

OneCare's Commercial and Self Insured contracts lag Medicare and Medicaid in transferring performance risk to the ACO.

(\*): After accounting for OCV's Medicare Risk Re-insurance, dollars at risk equal 2.8%.

# Distribution of At Risk Dollars by Payer

OneCare Vermont: % Distribution of 2020 Dollars at Risk  
(Total = \$44.1 million)



**Key Takeaways:**  
Medicare financial risk (including the amount covered by risk reinsurance) accounts for 62% of OneCare's aggregate at risk dollars. Medicaid is the next largest share at 26% of total dollars at risk.

# OneCare Risk by Risk Bearing Entity

Risk Bearing Entity	CY 20 Max Downside Risk	% of Total
UVM Medical Center	\$ 18,715,724	42.4%
Central Vermont Medical Center	\$ 4,971,384	11.3%
Northwestern Medical Center	\$ 4,303,405	9.8%
Porter Medical Center	\$ 3,447,724	7.8%
Dartmouth-Hitchcock	\$ 2,525,389	5.7%
Southwestern VT Medical Center	\$ 2,348,358	5.3%
Mt. Ascutney Hospital & Health Ctr	\$ 2,196,835	5.0%
Rutland Regional Medical Center	\$ 1,297,409	2.9%
Brattleboro Memorial Hospital	\$ 1,184,133	2.7%
Springfield Hospital	\$ 825,283	1.9%
Northeastern VT Regional Hospital	\$ 822,304	1.9%
North Country Hospital	\$ 785,616	1.8%
Gifford Medical Center	\$ 457,211	1.0%
Copley Hospital	\$ 237,667	0.5%
Grace Cottage Hospital	\$ -	0.0%
<b>Sub-Total</b>	\$ 44,118,442	100.0%
Medicare 3rd Party Risk Reinsurance	\$ (12,289,468)	
<b>TOTAL (Network Aggregate)</b>	\$ 31,828,974	

## Key Takeaways:

While risk bearing entities are individually at risk for amounts that total \$44.1 million, the impact of the Medicare third party reinsurance means that hospitals participating in Medicare will have access to the Medicare reinsurance pool—mitigating their total risk exposure.



# Hospital Maximum Risk Limits

Hospital	Total Risk (MRL)	Risk Mitigation	Est. Max Risk Limit (MRL) - CY20	Days Cash on Hand	MRL as % of Days Cash on Hand	Percent of System MRL
Brattleboro Memorial Hospital	\$ 2,368,265	\$ 1,184,133	\$ 1,184,133	121.6	1.4%	2.9%
Central Vermont Medical Center	\$ 4,971,384		\$ 4,971,384	75.0	2.2%	12.3%
Copley Hospital	\$ 475,334	\$ 237,667	\$ 237,667	72.1	0.3%	0.6%
Gifford Medical Center	\$ 457,211		\$ 457,211	241.4	0.9%	1.1%
Grace Cottage Hospital	\$ -		\$ -	87.7	N/A	0.0%
Mt. Ascutney Hospital & Health Ctr	\$ 2,196,835		\$ 2,196,835	134.1	4.0%	5.4%
North Country Hospital	\$ 785,616		\$ 785,616	201.8	0.9%	1.9%
Northeastern VT Regional Hospital	\$ 822,304		\$ 822,304	114.3	1.0%	2.0%
Northwestern Medical Center	\$ 4,303,405		\$ 4,303,405	279.2	3.7%	10.7%
Porter Medical Center	\$ 3,447,724		\$ 3,447,724	125.3	4.0%	8.5%
Rutland Regional Medical Center	\$ 1,297,409		\$ 1,297,409	204.6	0.5%	3.2%
Southwestern VT Medical Center	\$ 4,696,716	\$ 2,348,358	\$ 2,348,358	35.7	1.4%	5.8%
Springfield Hospital	\$ 825,283		\$ 825,283	3.7	1.7%	2.0%
The University of Vermont Medical Center	\$ 16,830,645		\$ 16,830,645	192.7	1.2%	41.7%
DHMC	\$ 640,310		\$ 640,310	N/A	N/A	1.6%
Total	\$ 44,118,441		\$ 40,348,284			

# Risk and Reserves

OneCare's FY 2020 risk model has changed since FY 2019:

1. Founders now assuming hospital-specific risk mitigation of approximately \$3.8 M
2. OneCare would like to retain the \$4 M in reserves that were previously set aside for specific hospital risk mitigation arrangements, for general liquidity concerns

# Risk and Reserves: Recommendations

15. Any further changes or developments to OneCare's risk strategy must be documented and presented to the GMCB.
16. OneCare must notify the GMCB upon its intended use of the \$4 M reserve, including the reason for drawing down the reserve. The use of this reserve shall be limited to population health investments and supporting participation of hospitals engaging in sustainability planning, unless otherwise approved by the GMCB.

# Evaluation

# Evaluating the APM and the ACO

Under the APM Agreement the GMCB reports on scale, cost, and quality:

1. Annual ACO Scale Targets and Alignment Report
2. Annual Health Outcomes and Quality of Care Report
3. Annual and Quarterly Financial Reporting
4. Payer Differential Report

In addition to these required reports, GMCB staff will leverage internal (e.g. ACO monitoring/reporting) and external (e.g. payer, ACO) sources to dig into and understand incidence and trends in scale, cost, quality, utilization etc.

# Example GMCB Reporting: Primary Care Spend Table

2018	Commercial		Medicaid		Medicare		Total	
	ACO	VT	ACO	VT	ACO	VT	ACO	VT
Primary Care Costs	\$	\$	\$	\$	\$	\$	\$	\$
Primary Care Costs PMPY	\$	\$	\$	\$	\$	\$	\$	\$
Primary Care Costs Percent of Total	%	%	%	%	%	%	%	%
Specialist Costs	\$	\$	\$	\$	\$	\$	\$	\$
Specialist Costs PMPY	\$	\$	\$	\$	\$	\$	\$	\$
Specialist Costs Percent of Total	%	%	%	%	%	%	%	%
Annual Percent Change in Primary Care PMPY	%	%	%	%	%	%	%	%
Annual Percent Change in Specialist PMPY	%	%	%	%	%	%	%	%

# Evaluating the APM and the ACO: Recommendations

17. OCV to develop a performance dashboard to be approved by the GMCB by the end of Q2 2020, including an implementation plan.
18. GMCB to develop and publish a dashboard comparing ACO to non-ACO and overall Vermont performance.

Dashboards shall reflect current and trend data/analysis on the following:

1. Quality
2. Utilization
3. Total Cost of Care
4. Attribution by payer
5. % FPP/FFS
6. Other metrics tied to the APM

# FY20 ACO Budget Recommendations



# FY19 ACO Budget Order

- GMCB Staff will also recommend carrying over a number of budget order conditions from prior year, some of which may overlap with FY20 recommendations
- FY19 Budget Order Highlights
  - Scale Target ACO Initiatives
  - All-Payer ACO Model Agreement data reporting
  - Payer contracts
  - Regulatory alignment
  - Maximum risk
  - Reserves
  - Administrative expense ratio and allocation
  - Financial statements
  - Population Health Management and payment reform programs/initiatives
  - Comprehensive Payment Reform (CPR) Program reporting
  - VBIF distribution methodology
  - Specialist payment pilot and community innovation fund reporting
  - Certification monitoring and reporting (updated policies and procedures)

[2019 Budget Order](#)

# Summary of Recommendations

## Provider Reimbursement:

1. OneCare to report annually on percentage of provider payments that are fee-for-service versus fixed prospective payment by provider type and by payer.

## Payer Programs:

2. OneCare to provide final payer contracts upon signature. Final payer contracts must qualify as scale target initiative, otherwise OCV must justify to the Board, and must align with Medicare on attribution methodology, quality metrics, payment and risk terms, and services included in financial targets. Inline with the 2019 budget order, OCV must justify any material differences between programs.
3. OCV to come before the Board on a date agreed upon by both parties, but no later than April 1, 2020, to present final attribution, revised 2020 budget, and final payer contracts.
4. OCV must create a one-pager on the benefits of self-funded programs of contracting with OCV.
5. If geographic attribution is implemented in the Medicaid program, OCV to provide an implementation manual.
6. OCV must meet the following trend rates:
  - Medicare – recommendation for 3.5%, potential vote December 18, 2019
  - Medicaid – recommendation to adopt % within Wakely range, upon Medicaid Advisory Rate Case
  - Commercial (QHP and Self-Funded) – As in FY 2019 OCV to provide the Board with...
    1. Actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive
    2. An explanation of how its overall rate of growth across all payers fits within the overall all-payer target rate of growth and, if its overall rate of growth exceeds the target, how it plans to achieve the cumulative target for the term of APM Agreement (2017 to 2022)

# Summary of Recommendations continued

## **Provider Network:**

7. OCV must submit a 2021 Network Development Strategy that includes the following elements:
  - A definition for ACO “network composition” necessary to maximize value-based incentives
  - Provider outreach strategy
  - Provider recruitment and acceptance criteria
  - Network development timeline
  - Providers dropping out of the network (quantify) and reasons why
  - Challenges to network development

## **Scale:**

8. OCV to report formally on status of their Scale Target Memo follow-up items during presentation on final attribution, revised budget etc.

## **Model of Care and Population Health Investments:**

9. If Population Health Management (PHM) Programs are not fully funded as detailed in OneCare Vermont’s 2020 budget, OneCare Vermont will put forth a revised proposal to the Board.
10. PHM investments shall report by HSA quarterly, by program, and by provider type.
11. OneCare Vermont will use their community-specific population health investments (innovation fund and specialty pilots) to address cost and quality differences across Health Service Areas as identified in their variations in care analysis. These investments shall be evidence based, be assessed for return on investment, and be tracked by the ACO.
12. OneCare Vermont shall develop a workplan to evaluate the effectiveness of any population health investment, including analysis for how to scale those that are successful, sunset those that are not and report on opportunities for sustainability. This plan could include but not be limited to the entity, funding amount, evidence for funding, distribution plan for funding, scope of project, timeframe, measurable outcomes, and risk/issues/challenges. The analysis should be submitted to the GMCB in the first quarter of 2020.
13. OneCare Vermont shall provide a mid-year update on the 2020 complex care coordination program to include data on enrollment, payments, and any challenges or learning opportunities.

# Summary of Recommendations continued

## **Administrative Expense:**

14. If total revenues are projected to increase, the administrative expense ratio shall not exceed 1.35%, and if total revenues are projected to decrease, the administrative expenses ratio shall not exceed 1.60%, unless otherwise approved by the Board. The Board will review this condition based on final attribution.

## **Risk and Reserves:**

15. Any further changes or developments to OneCare's risk strategy must be documented and presented to the GMCB.
16. OneCare must notify the GMCB upon its intended use of the \$4 M reserve, including the reason for drawing down the reserve. The use of this reserve shall be limited to population health investments and supporting participation of hospitals engaging in sustainability planning, unless otherwise approved by the GMCB.

## **Evaluating the APM and the ACO:**

17. OCV to develop ACO performance dashboard to be approved by the GMCB by the end of Q2 2020, including an implementation plan. The dashboard shall reflect current and trend data/analysis on the following:
  - Utilization
  - Quality (tied to APM)
  - Total Cost of Care
  - Attribution by payer
  - % FPP/FFS
  - Other metrics tied to the APM

# Other Recommendations

Other requirements as part of OCV budget revision:

1. Expected hospital dues for 2020 by hospital
2. 2020 PHM source of funds by payer/hospitals
3. Hospital risk addendums
4. If DSR/IAPD funds are granted, what are their planned use?

# Next Steps

# Next Steps

1. Board vote on OneCare Vermont's FY20 Budget and Medicare Benchmark growth scheduled for December 18<sup>th</sup>, 2019
2. GMCB to produce FY 2020 Budget Order
3. GMCB staff to update ACO monitoring plan
4. GMCB to continue posting quarterly ACO monitoring and reporting materials
5. GMCB staff to present on APM quality results in early 2020
6. OneCare Vermont to provide final payer contracts, final attribution, revised budget and present to the Board by April 1, 2020
7. First annual report on APM will be published in fall 2020 (NORC)
8. GMCB staff will continue to update the Board on the development of ACO performance dashboards
9. GMCB will post Medicaid Advisory Rate Case and 2020 Medicare contract once publicly available
10. GMCB staff will continue to meet regularly with the Health Care Advocate

# Regulatory Integration



# Regulatory Integration

- GMCB staff have already begun identifying process improvements and opportunities to link regulatory processes
  - A white paper highlighting specific opportunities for regulatory integration is under development by GMCB staff and Board members
  - GMCB staff to work with the Health Care Advocate to identify potential opportunities to link inputs and outputs between ACO budget, hospital budget, and insurance rate review processes
- Due to the depth of content we had to cover today, and in order to give the topic the time it is due, GMCB staff will return in the new year to discuss regulatory integration and opportunities for process improvement

# Questions

# Public Comment